Ghana

Mobilizing Communities for Safe Motherhood

An intervention in Ghana demonstrated the value of individual, family, and community education in reducing barriers to appropriate care for childbearing women.

Overview

A recent study of CEDPA's safe motherhood pilot study in Ghana outlined some exciting results after only 10 months, including the establishment of community emergency plans covering: emergency funds, transport, blood donors, elimination of the most dangerous traditional practice, and seeking antenatal care earlier in pregnancy. This pilot study tested the following hypotheses:

1. Women and families who have received counseling from expanded role community-based distributors (CBDs) will be able to identify obstetrical complications, self-refer for care, organize a birth plan for a planned normal home birth, and organize an emergency birth plan for unanticipated complications.

2. Communities, which have been sensitized to the issues of excess maternal mortality and morbidity by safe motherhood advocates, will actively work to decrease barriers to accessing appropriate care.

The work was accomplished through a local non-governmental organization (NGO) partner, Amasachina Self Help Association, located in rural northern Ghana.

Situation Analysis

The Ghana baseline study revealed problems that were cultural, socio-economic, and related to gender. Nine in ten residents of the three project communities were illiterate. They had little knowledge about safe motherhood practices. Women's diets were found to have limited protein content. Beliefs prohibited women from eating eggs, chicken, and other good sources of protein.

Also, in the study area, poverty, bad roads, long distances to referral facilities, ill-equipped health facilities,

and providers who were inadequately skilled to manage obstetrical complications contributed to the problem of high mortality. The three communities also lacked plans for normal birth preparedness or for emergencies and complications.

Husbands, who culturally should announce their wives' pregnancies, did not do so until after the performance of a rite when the woman is five months or more into her pregnancy. Women therefore did not attend antenatal clinics until the late second or early third trimesters due to waiting for the pregnancy announcement ceremony.

There was liberal and universal use of kalugotin, which was given antenatally and during labor to ensure an easy birth. However, this practice can also lead to an increase in ruptured uterus, severe neonatal asphyxia, and death of mother and baby. Hospital personnel report that the communities have been resistant to changing these practices.

In Ghana, newborns were not put to the breast until the third day after delivery. The babies were fed on shea

butter, put in warm water, or fed by a "wet nurse." Families were found to have limited plans for a normal home birth, no emergency plans, and spotty knowledge regarding complications and appropriate level of referral to access emergency care.

The strategy for this intervention was to train two cadres of community volunteers: the safe motherhood advocates (SMAs) and the safe motherhood volunteers (SMVs).

- The safe motherhood advocate is an individual who feels passionately about preventable maternal and newborn deaths and works with communities to decrease these deaths and associated illnesses through advocacy and reducing barriers to care.

- The safe motherhood volunteer is an individual who feels passionately about preventable maternal and newborn deaths and works with his/her own community to decrease deaths and injuries through education of pregnant women and their families on early recognition and self-referral for problems, and how to plan for a safe home delivery and for any complications that may occur.

The SMAs and SMVs were trained in collaboration with local NGO partners. Where trained CBDs were already available, they were given the additional SMV training. Competency-based checklists were used in the training and by the NGO supervisors in their weekly supervision visits to the communities. The training included participatory learning activities that were practiced in the classroom and/or a village field trip. These same techniques were used by the SMAs to develop community consensus regarding local barriers to safe motherhood and to develop an action plan.

Results in Ghana

In the first 10 months of the northern Ghana intervention several remarkable changes were noted. Women are now allowed to receive antenatal care prior to the official announcement of pregnancy and performance of announcement rites. Husbands encourage their wives to eat the right food and to prepare for the coming baby by providing the money needed. Some assist in carrying heavy loads on their bicycles.

The chief, elders, and the entire community have worked cohesively with the SMAs and SMVs to establish systems, including an emergency fund, plan for emergency transportation, blood donation, and to accompany the woman to the hospital during an emergency. Members of the communities have generated an emergency fund and liaise with the transport union and district chairman's office to ensure that a vehicle is available when needed for emergency transfers. In one community, the paramount chief commits himself and his vehicle to convey women to the best-equipped referral center in the district, which is 20 kilometers away. The SMAs and SMVs have established regular meetings with members of the community to identify, discuss, and prioritize problems, evolve solutions, and translate them into action plans.

The use of kalugotin has been discontinued in the three project communities in Ghana. One elder said, "We have stopped using kalugotin because we now know that it is dangerous to our wives and babies." Also, babies are now put to breast within two hours of birth.

The volunteers report no known deaths in the study area in the first 10 months of the intervention. This contrasts with four maternal deaths (including one from snake bite) reported in the prior year.

Although it was expected that the intervention would yield change at the family and community levels, unanticipated change has already begun at the government and health system levels through:

- Demand that a midwife who is performing poorly be removed from their clinics.

- A pledge from the local government that:
  - The safe motherhood advocates will be provided bicycles to assist in their work;
  - Two local community midwives will be sponsored for life saving skills training in the referral hospital; and
  - Two community nurses who attend births will be sent for midwifery training to better handle both normal and complicated pregnancies.

Communities do care deeply about what happens to their pregnant women and can be mobilized to promote safer practices and higher quality care.

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1400 16th Street, NW, Suite 100, Washington, DC 20036, USA
Tel: 202-667-1142 Fax: 202-332-4496 Website: www.cedpa.org

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